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COMPLIMENTS OF
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EXPERIENCE AND INCIDENTS

OF

691 OBSTETRICAL CASES.

PRESENTATIONS AND MODE OF DELIVERY.

BY DR. N. GUHMAN, M. D.

Read before the St. Louis Medical Society.

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EXPERIENCE AND INCIDENTS OF 691 OBSTETRICAL CASES.

PRESENTATIONS AND MODE OF DELIVERY. MALES, FEMALES, ETC.

Read before the St. Louis Medical Society.

BY DR. N. GUHMAN.

MR. PRESIDENT AND GENTLEMEN:—The paper I am about to read may not be of so much interest to the older members as to the younger, however we may all profit some by it, when we think back of our past doings.

I had vertex presentations,	586
Face presentations,	9
Breech, feet and knees presentations,	71
Shoulders, arms and hands presentations,	49
Twin cases,	24
Natural delivery,	490
Forceps (including craniotomy—2 cases) 22%,	150
By turning,	73
Not delivered,	2
Male children born,	383
Female children born,	330
Unborn (or not delivered),	2
Still born,	116
Hydatits (grape moles),	5
Prolapsus of the cord,	17
Prolapsus of the cord reduced and children born alive,	8

Placenta prævia,	9
Placenta prævia diagnosticated, but not treated by me,	3
Placenta prævia—fatal to mothers,	3
Puerperal convulsions before delivery,	4
Puerperal convulsions before delivery—fatal to mothers,	2
Puerperal convulsions after delivery,	2
Puerperal convulsions after delivery—died,	1
Rupture of the uterus (all fatal),	4
Mothers died before delivery,	3
Deaths caused by exhaustion,	2
Death caused by puerperal convulsion,	1
Cases with physicians and midwives,	258
Cases of my own,	433
Vertex presentations (my own),	410
Face presentations (my own)	none.
Breech, feet and knees,	27
Shoulders, arms and hands,	9
Twins,	13
Forcep delivery, 7½ per cent.,	32
By turning,	13
Natural,	401
Still born,	37
Placenta prævia (one fatal)	2
Puerperal convulsion before delivery (not fatal),	1
Puerperal convulsion after delivery (fatal)	1
Post partum hemorrhage (nearly fatal),	1
Hydatits (grape mole),	1

In connection with these 691 cases I do not propose or pretend to go into all the details, except what I have observed, and which will be of some practical interest to the profession, and to explain why and what are the causes of the great number of still born children, and how it came that the obstetrical forceps were used so often. What does obstetrical statistics amount to—even if one physician alone would do all the obstetrical practice in a county or state? Because one physician would use the obstetrical forceps where another would not, and probably resort to turning, or Craniotomy, or leave it to nature.

I have known physicians who had been practicing medicine and obstetrics for twenty-five years and longer, and never used the forceps; so it would be with all other obstetrical operations, or mode of delivery. The same holds good in hospital practice, because you only get a certain class of patients, mostly young women who have no homes. A physician who follows obstetrics in private practice will naturally get more cases where trouble is expected. The women will say, I will not engage a midwife, because I have to get a physician with the midwife every time; I can save that (midwife's) money and get a physician at once. I had ladies where forceps had to be used at every delivery. I remember of at least four ladies where there was a shoulder presentation every time. Two ladies I delivered five and six times with a shoulder presentation. One woman I delivered five times with a breech presentation, and a still-born mortified baby every time. Husband and her denied having had syphilis.

I will take up every article which is of interest to the practicing physician by itself as I proceed in my paper. Out of these 691 cases I was called in 258 cases by physicians and midwives, and in some of these cases I had to call on other physicians to assist me. Out of the 691 cases there were 24 twin cases, which would make the number of children 715. Out of the 715 children born 116 were still born, which was due to several causes:

1st. Where death took place within the uterus days before delivery; probably caused by syphilis and accidents.

2d. Delay and too long awaiting to act, either one way or another, which made cases more dangerous to mothers and children.

3d. Prolapsus of the cords.

4th. Malpresentation or position, such as shoulders, feet, knees and breech.

And lastly—narrow and deformed pelvis, rigidity of the os and perineum, feeble and slow action of the uterus.

I remember cases where mothers and children died on account of ignorance of midwives. I remember a case where a midwife tried to deliver a woman where the head of the child was born over one hour before my arrival, and this was the

largest child born in my practice. I was sorry I did not weigh it; its weight must have been from 15 to 18 pounds; both parents were large and strong.

In another case I was called where the child was dead within the uterus, fully dilated, and a prolapsed cord, and the mother in a dying condition. She died in about fifteen minutes after my arrival (the midwife had left her and ran off). I could have delivered that woman before she died with forceps, but I was afraid that the women in the room might have thought I killed her. She died of exhaustion and undelivered.

In another case where a midwife had a shoulder presentation, and a hand protruding out of the vagina, from Sunday afternoon to Monday morning, when I was called in to deliver her. I turned the child with difficulty, and still born.

In another case of a physician, a shoulder presentation and the hand protruding out of the vagina, with a string tied around the wrist, and tried to deliver her. I turned, and delivered her with a still born child. I could enumerate many such cases which increased the number of still born children.

A physician who has done any obstetrical practice knows that some children perish during labor, or a short time after birth, and you do not know why. In my own cases of 446 children, 37 were still born, which was partly due, as above mentioned, where they expected tedious or faulty labor, and would not engage a midwife. With a little more work I could have separated the still born males from the females, and those from the instrumental and turning cases, and those that died in the uterus before labor commenced, which, however, does not make much difference. Of the 715 children delivered, 105 were delivered with forceps, or nearly 21 in a 100; where in my own cases, 446 children, I delivered 32 with forceps, or little over 7 per cent.

In regard to using forceps as being dangerous to either mother or child, I would say from my own experience, when forceps are properly and carefully used, at the proper time, there is very little danger to either child or mother. I always used the long (Hodges) forceps in the superior or inferior pelvis. I think that the obstetrical forceps is the best friend to woman when in need. It may be said that the use of forceps

is very dangerous to perineums. I am positive that the use of forceps in careful hands will save perineums from being ruptured; when you have the forceps on the child's head you have something to guide the head over the pubis, and to relieve the tension of the perineum. Perineums will rupture with and without forceps; a good deal depends on the tissues and rigidity of the perineum—some are more elastic than others. I have seen the worst ruptures of perineums where the forceps were not used. The proper way of using forceps after the child's head is disengaged, is to guide the child's head with the forceps with one hand, and support the perineum with the other, and when the pain comes on, make slight traction when needed, and when the pain ceases, let the forceps recede with the head of the child, and unscrew the lock, so as to keep the pressure of the forceps from the child's head. With such procedure there is not much danger of rupturing the perineum; the perineum will not be taken by surprise, it will have time to dilate and stretch. Of course no physician who uses forceps will forget to empty the bladder and rectum. I often thought, and am positive of my assertions, that after delivering the child's head with forceps or otherwise, the perineum was often, and more so, ruptured with the shoulders, and not with the head of the child. In my observation I found in the majority of the cases where the child's head was impacted in the pelvis, was due that the rotation of the child's head was not completed, and in some cases it is due to a small, narrow pelvis. In a feeble or completely arrested contraction of the uterus, or labor pains, I would prefer the use of forceps to ergot. It seems to me I could control the forceps better, and more to the safety of the mother, and perineum, than to the action of ergot. In some cases of head presentation in the superior strait, I would prefer turning to the use of forceps. In a case where a head was presenting in the superior strait, the uterus fully dilated, and the child's head would not descend, or engage in the pelvis, probably caused by a short cord, or shortened where the cord is so wrapped around the child's neck several times, I would turn and press the uterus with one hand from the outside of the abdomen along down, so as not to separate the cord between the child and the placenta]

attachment; by resorting to turning in such cases, where the cord is wrapped around the neck of the child several times, the head would rise up near to the attachment of the placenta, the tension of the cord would be lessened, the cord may unwrap itself and the danger of the child prevented. Some authors recommend to reach up to the neck with the fingers and unwrap the cord. I think the last method is not so easy done. I would not mention these cases, but I had several such, where I could not bring the head down in the pelvis with the forceps, where I had to resort to turning, and delivered without any trouble.

I will relate a case which was very interesting, and of some thought to me. I was called by a physician to assist him in a forceps case. He had the forceps on the child's head for some time, and tired out, when I arrived. I relieved him and tried my hands on the case. With my forceps I did not notice the least advancement of the child, and the woman almost in a dying condition. I advised the attending physician to take the forceps from the child's head, as there was no advancement of the child whatever. He asked me if it was advisable to send for some other physician with a crushing forceps. I had nothing against the proposition, and we sent for Dr. Papin. I removed the forceps and laid the woman comfortable across the bed, more dead than alive. About one week before, I was reading in a medical journal of a similar case, where, after the attending physician had laid the woman in the bed, she got her child without any assistance, and unbeknown to anybody. In having that case in my mind, I remarked to the attending physician and told him about that case, of which I had read about a week ago, and I warned him to watch the woman that the same may not happen here. I watched the movement of the woman, the other physician was out in the hall to see if Dr. Papin was coming; all at once I heard a groan, and an expulsive movement of the woman. I raised the bed clothing, and to my astonishment the child's head was emerging over the perineum, and was born. The attending physician with Dr. Papin came into the room at the same time, and I showed them the baby, still born. The woman died about seven hours afterwards from exhaustion and shock. The question arises,

what was the cause of all this state of affairs? Did the forceps interfere with the rotation or mechanism of labor, and prevent its descent? Or was the expulsion of the child due to the relaxed condition of the mother, after we removed the forceps from the child's head. My opinion always has been that the forceps were applied too soon—probably when there was no need of it. Although I did not know what the condition of the mother or child was when the forceps were applied.

I will relate two more cases which are interesting, and in doing so I do it more to warn physicians to take the proper precautions; when they are called to a case where there is some responsibility attached to it, to call in one or two other physicians to witness the operation for our own protection; sometimes we can not do so—where we have to act at once.

I was called one night to see a woman in labor, with nobody at her bedside except her husband and myself; after making an examination I found the mouth of the uterus high up and fully dilated; the water broke before my arrival; labor pains were very strong and expulsive. I also found on the posterior and lower part of the pelvis an elevation of cartilaginous tissue, which obstructed the inferior pelvis to a very small size. I informed the husband and his wife that it would be impossible for the child to pass through that narrow constriction, and that there was only one way to deliver her—by the Cæsarian operation; if not, she would be ruptured, I did not know to what extent, and I insisted to call in some other physician, although I did not think that anything could have been done under the circumstances, because the labor pains were so strong and frequent, and the time too short to get any assistance, and being in the night when it would have taken some time to get any assistance, so the husband told me I should do the best I could and he would be satisfied; that she was ruptured at her previous delivery, which accounted for the cartilaginous condition in which I found her. All at once a strong expulsive pain came on and the child was expelled. After examining the woman I found that she was ruptured from the elevated cartilaginous obstruction along through the bowel, perineum, sphincter ani. I sent for Drs. W. H. Cooper and Maughs; we cleaned out the vagina and sewed the ruptured part up with

silver wire sutures. If I remember right, we made about eighteen sutures. We gave her opium to lock up the bowels, and had her syringed with carbolized warm water, catheterized the bladder three times a day, and within one week every part of it healed without any suppuration. I was glad that I was out of my trouble; I told her if she ever got pregnant again not to send for me, that I would like for somebody else to have the honor to do so. With the permission of Dr. Maughs, I would relate that he was the next victim who had the honor, all by himself, to deliver her. Within two years she got pregnant again; she sent for Dr. Maughs in a very cold and snowy night, and the doctor not knowing who he was called to. She had moved to a different part of the city. After quite a little while Dr. Maughs, after examining her, asked his lady patient if she was not the lady he sewed up about two years ago, with Drs. so and so? She answered in the affirmative. Dr. Maughs thought that she might have spared him that trouble, and as the doctor could not very well get out of it, and with his great heart and love for women when in need, gave her all the assistance he could until she was delivered, with the same result of rupturing the parts as before. The results of the operation, sewing up the rupture, was not as successful as before. Last winter the woman came in my office, as a charity patient, to get a prescription for a cough she had. Knowing of her condition, informed by Dr. Maughs, I asked her to let me examine her to see what her condition was; she told me that she was not in a proper condition at the present time to be examined, as she had no control over her bowels. She promised me that she would come some other time and I could examine her, but she never came, so I do not know what condition she is in.

The second case, which I will relate now, is more important and interesting than the other, and which will be very much in favor of using the obstetrical forceps in time.

One afternoon, about two o'clock, I was sent for by a midwife to deliver a young woman with her first child. I made an examination and found the child's head in the inferior strait, near the outlet, impacted; rotation was fully completed, and hardly any labor pain. The midwife informed me that the child's head was in that position for the last three hours,

and made no progress. I insisted that the woman should be delivered, and explained to the husband and to the patient's mother, who was present, the consequences of delaying the delivery so long. The mother would not listen to my advice and remonstrated against it, and said that she herself had many children born without instruments and she would get her child to. I told her that she was responsible for her action and that she should not blame anybody for the consequences, which I predicted to her. I left the house, telling her that if they waited over one or two hours longer that it would be one of the worst acts of humanity I had ever seen. All this talking did no good, and it did not soften the old lady's heart. I left the house and went home. I did not hear anything about the case until about eleven o'clock at night. I came home. My son, a young M. D., informed me that these parties were here, and that I should go to their house and deliver her. I told my son that I did not like to have anything to do with the case, after waiting so long, and explained to him the danger of sloughing of the vagina, and having fistula of the bladder or bowels. He begged and insisted for me to go, so that he could see the operation. I yielded to his pleading and went. When I got there I found the child's head in the same position as it was in the afternoon. Upon examination I found a greenish, watery discharge, with a peculiar odor, from the vagina. The touch of the vagina was something like fine sandpaper, which was caused from the granular condition of the mucous membrane, produced by the too long pressure of the child's head upon it. I explained to the parties again what I expected from the condition the vagina was in—sloughing, and probably a fistula of the bladder or bowels, and they must not think that if I deliver her, that the forceps would cause it, and if it was not for humanity's sake I would not deliver her. I took all the precaution before applying the forceps. I emptied the bladder with much difficulty—the bowels were empty—and applied the forceps and delivered the woman with a still born child in less than five minutes, without any great force or the slightest injury to herself; not a sign of a rupture, which was very lucky for me from the hereafter accident. After she was delivered I was very anxious about the bladder and bowels, and drew off her

urine three times a day for three or four days, and afterwards she passed her urine without any assistance, by herself. I used vaginal injection with warm carbolized water every three or four hours. I attended her for thirteen days, with the bladder intact; several days before my last visit I found her dressed and about the room, but could not get her to syringe, or to lay in bed, or to do anything for herself, although I warned her that she was not out of danger from a fistula which I still apprehended, from the secretions of her vagina. I was taken sick about that time and could not see her any more. My son took charge of her and visited her for several days. He told me it was no use to see that woman any more, that she would not do anything for herself, and the bladder was still intact. About six weeks afterwards the midwife who had attended her came in my office and informed me that we both would get into trouble about that woman, because she could not hold her urine in the bladder and it was dripping away through her vagina, and a very eminent surgeon had her in charge, and that there was a lawyer at the back of it. I immediately went to the attending surgeon's office to inquire about the case; he was not in, and he called at my office and informed me about the condition of the woman, and said it was the largest vesico-vaginal fistula he had ever seen, and he also told me that there was a lawyer in the case. I explained to the attending surgeon as I have stated above, and he thought that nobody was to blame for it but themselves; the doctor also informed me that he had operated without success. I at once went to their house, and to some of the neighbors who witnessed and knew all about the affair, and took their names—not only to defend myself, but to prosecute them for blackmailing and slander. The old mother, who was the cause of all her daughter's trouble, begged off, and said to me that she did not say anything, and it was all her son-in-law's doings. I have not been troubled any more since. I felt sorry for the young, inexperienced woman; she would not have objected to be delivered with forceps when I was first sent for, if it had not been for the advice of her mother. I hope my brother physicians will learn something from this case and will not forget to fortify themselves and take all the precaution to save themselves from blackmailing and a damage

suit, which is very often our reward for doing charitable and humanity works.

I have seen four cases of rupture of the uterus before delivery. In one case I think it was caused by giving ergot; in two others they were cases of hydrocephalus. In one case the child's head measured around the forehead 22½ inches, and from one ear to the other, 15 inches. In the other case I did not know the cause. The women all died. I have seen five cases of hydatits from six to eight months' (suspected) gestation, some with considerable hemorrhage before they were diagnosticated; only one of these five cases came within my own practice.

Prolapsus of the cord is one of the causes of still born children, not so much so if the case is detected in time, and properly attended to. I always managed to slip the cord up over the head in a head presentation between the pain, and as soon as the head was well engaged it would not come down any more. In breech, knees and feet presentations it is not so easy kept up, and the success lays in the rapid delivery of the child. The two cases mentioned where the mothers died before they were delivered, one was the one mentioned before in the paper which was in a dying condition when I was sent for. The other case was a woman of about forty years of age; first she had a midwife, and then Dr. Hanzeman, myself, Dr. Papin and Dr. Yarnel. We found the child in the superior strait, head presenting—it was not impacted; we could not get it down, neither one way or another, by forceps or turning; when we left the woman she was in a dying condition undelivered, and died several hours afterwards. We all were very anxious to have a post-mortem examination to find out where the difficulty was; we suspected a monster of some kind. The husband was very ignorant, but positive in his action, and he would not allow us to have a post-mortem examination; he threatened to kill us with an ax if we made an attempt to do so. I consulted with the coroner to force a post-mortem examination; he knowing the eccentricity of the father, and the neighbors to side with him, he thought we had better not insist on a post-mortem examination, as it would have taken a corporal's guard to protect us from a mob. His suspicion and superstition, and

believing that we doctors would steal the body from the graveyard, made him a guardian over his wife's grave for some time after her burial.

Twin Cases.—I had 24 out of 691 cases, and 13 twin cases of my own in 433 cases. Placenta praevia, I had nine cases. My first case of placenta praevia (fatal) was in the hands of a very old practitioner. He came to my office late in the evening, and asked me to go with him to see a woman in labor who had hemorrhage all day. I told the doctor I thought he had a case of placenta praevia; he then told me that he did send for two eminent obstetricians during the afternoon, but they did not come, and he was afraid to wait any longer. When I arrived at the house I found the woman almost pulseless from the loss of blood. After an examination, I found the uterus fully dilated. The water was not broken, and the placenta was separated from the uterus and detached; labor pains had ceased. By request of the attending physician, I turned and delivered the woman of a still born baby; the woman died during the night.

The second fatal case was a woman who had a midwife; she was bleeding all day, and the midwife telling her that a little bleeding would not amount to anything, and left the poor woman to her fate for over the night. During the night the husband got alarmed, and came for me. From the history he gave me I suspected placenta praevia. On the way to the patient, I called on my son and sent him for Dr. Yarnel to assist me, and divide the responsibility. Upon examination I found the uterus well dilated, and the placenta was centrally attached to the uterus. I sent the man for ergot, and when my son came with Dr. Yarnel, and before giving the woman a dose of the fluid extract of ergot, I reached in the vagina with my left hand and separated the placenta on one side of the uterus. I reached up and took hold of two feet, turned, and delivered the woman without much trouble or hemorrhage. She died two hours afterwards from the loss of blood and shock.

The third fatal case was the saddest of all: a mother of twelve living children, she was a robust and healthy woman. A midwife was sent for first; she recognizing placenta praevia, she sent for me. I found the woman up and about, attending

to her household. Her time of gestation being nearly completed, and she was bleeding at times a very little. I found upon examination the mouth of the uterus only enough dilated to put my finger in. I found something soft across the small opening, which I thought was the placenta. She had no labor pains at any time. I advised the woman to go to bed, and keep as quiet as she could, and there was no more hemorrhage. I gave her instructions that if any labor pains or bleeding should come on, to let me know at once. I made all preparations for her safety, at the same time I informed my friends, Drs. Papin and Yarnel, and asked their assistance, which they promised cheerfully. I watched the woman for about eight days. One afternoon labor pains came on, with some slight bleeding. I made a small plug of cotton, saturated it with diluted perchloride of iron, and applied it on the bleeding surface, then I plugged up the whole vagina with cotton. I sent for my friend Dr. Yarnel at the same time. There was no hemorrhage which amounted to anything. We left the plug and the cotton in the vagina for two hours, and then removed the whole. We found the uterus dilated enough to get in with a hand. The placenta was centrally attached over the mouth of the uterus. We concluded to detach the whole placenta at once, and turn, and let the child act as a plug, or compressor, to the bleeding surface. Before we operated we gave the woman a dose of fluid extract of ergot. We had a syringe on hand, hot and cold water, ice, and also perchloride of iron, with cotton on plates, we were prepared for any emergency to stop the hemorrhage if we should have any. Dr. Yarnel performed the operation and delivered her of a live child in hardly no time. After delivery we found that the lips of the mouth of the uterus, where the placenta was attached, were separated and turned outwards; where we had considerable hemorrhage from those parts we used the hot water, alternated with ice; on the bleeding surface we applied cotton plugs saturated with perchloride of iron, and gave her the fluid extract of ergot internally. We succeeded in arresting the hemorrhage, and our patient was doing very well for about 25 or 30 minutes. All at once she collapsed, and we did not know if it was due to the loss of blood, or shock, or embolism. I thought it was the latter. The woman died in about two hours.

I remember a case where I was called on and found the woman laying on the floor, and everything about her saturated with blood, a physician standing before her, and did not know what to do; he did not know it was a placenta praevia. I reached with my hand in the vagina, and found the whole placenta detached, loose in the vagina, and a relaxed and dilated uterus. I turned and delivered the woman, and she made a quick and good recovery.

The other cases I detached the placenta either on one or the other side of the uterus; sometimes I would detach the whole placenta before turning, it all depended on circumstances and conditions which the patients were in. I do not believe that the same rule and mode of operating holds good in every case; you have to be guided by circumstances and conditions which exists, and use your own sound judgment. I came to the conclusion that in placenta praevia it is about the same as with other diseases, or surgical operations, some patients will get well in spite of mismanagement and accidents, while others will die with the best care, and under the most favorable circumstances.

I had four cases antepartum eclampsia, with two fatal cases; and two cases postpartum eclampsia, with one fatal case. The first case was a woman of about 26 years of age, her first pregnancy. She took convulsions about 8 o'clock A. M. No sign of labor pain. She was edematous all over her body. I bled her, and gave her large doses of calomel with sugar, dry on the tongue; injections into the rectum to move the bowels. We had no chloral and bromides at that time, and we had to resort to opiates and chloroform. The woman was doing very well; she was walking around the room all morning. In the afternoon, about 1 o'clock, she took another convulsion, and continued to have one about every 15 or 20 minutes. I sent for Dr. Papin, and we came to the conclusion to empty the uterus and deliver her if we could, but she died before we succeeded. I extracted a dead male child through the abdomen after the patient died.

The second fatal case was a young woman, first pregnancy of about eight months' gestation, no labor pains. After the first convulsion she became unconscious and died within two hours.

The most remarkable case, of which Dr. Maughs reported a part in the St. Louis Obstetrical and Gynaecological Society on December 15, 1887. When I was first called to see the woman, about 18 or 20 years of age, first pregnancy, she had had convulsions for five or six days, no labor pain; she was totally unconscious and comatose, and no urine in the bladder. I sent for Dr. Cooper and we bled her about three different times. On account of her comatose condition we could not medicate her much, and she kept in that same condition. Dr. Cooper and I came to the conclusion to empty the uterus by artificial means. We sent for Dr. Maughs, with instructions to take his uterus dilator and instruments with him. When Dr. Maughs came and heard the history of the case and the condition of the patient, he was of the same opinion as Dr. Cooper and I, that under these circumstances it was advisable to empty the uterus, as there was all the evidence that pressure was made on the kidneys from the extended uterus; and upon a careful examination we found the child was dead. Dr. Maughs first introduced Molesworth's Dilator until he could introduce his finger into the cervix, then he introduced the Barnes' Dilator (water bags); after he had the mouth of the uterus sufficiently dilated to introduce his fingers, he ruptured the membrane, and opened the child's head, letting the brain out, and delivered with forceps. I think the whole proceeding took about two hours. The woman was so comatose and unconscious that she did not make any movement during all the time we operated on her without an anaesthetic; she did not know for ten days afterwards that she was delivered. After the uterus was empty she kept in that condition for several days and then she became somewhat more conscious at times and the kidneys commenced to act again. We kept her strength up by enema with milk, beef tea and whisky, until she took nourishment by the mouth. On the night of the tenth day she dreamed that she had a baby and she was looking for it around the bed. Her husband informed her then the first time that she had her baby, but did not tell her how she got it; he told her in a mild way that the baby died, and she was satisfied and did not ask any more questions. She got well and I delivered her several times afterwards, once with twins (girls).

Post Partum Hemorrhage.—I do not know if we should call all hemorrhages after labor in the proper term or sense of the word post partum, such as are caused by retention of clots of blood or a small portion of placenta. Every practitioner will meet with a good many such cases. I have met with only one case that I would call post partum hemorrhage in my practice. The woman was delivered without any trouble or accident; I was attending to the child when the woman called me to her side and told me that she felt very sick and faint and she could not see very well. She felt a blindness coming over her eyes; she looked pale. I removed the bed clothing and found the uterus completely relaxed and distended to the size before delivery, and full of blood. I introduced one hand inside the uterus and the other outside of the abdomen and emptied the uterus, and contraction followed. I kept my hand from outside the abdomen on the contracted uterus to prevent another attack; all at once the uterus under my hand relaxed and extended itself like a rubber ball. I emptied the uterus again the same way as the first time, and I thought everything was all over. All at once the same thing repeated itself again, and hardly anybody would believe it—having a contracted uterus under your hands, thinking fully under your control, and lifting up your hands like they were nothing. This time the uterus would not contract like it did before. I closed my fingers, and tried if it would not contract around it. There was no response; I told the husband to get a pitcher of cold water, hold it high up and pour it over the abdomen, which had the desired effect. It was not very long before the uterus went through the same movement again; the only resource I had was the cold water and the manipulation with my hands; I was not prepared for any such accident, had no ergot and no time to send for it. At the same time I lowered her head, elevated the pelvis, and compressed the aorta through the abdominal wall. The woman bled so much that she could not bleed any more; she was blind, cold and pulseless, and I thought she would die. However, after that condition the uterus did not relax any more, and I began to give her stimulants, brandy, milk and beef tea. I kept my hand over the contracted uterus for four hours. The woman made a good recovery.

Retained Placenta may be due to various causes, such as uterine, inertia, hour-glass contraction, spasmodic contraction of the mouth of the uterus, and adhesion, either partial or complete. Of the latter I remember where Drs. Cooper, Maughs and myself worked once for six hours to detach and remove the placenta. We succeeded in getting it away by small pieces. The woman was more dead than alive by the time we were done. She made a good recovery.

Some authors claim that a complete adherent placenta should be left, until nature began to detach and remove it. I always found that a retained placenta was a great source of irritation and constitutional disturbances to the mother. After the birth of the child the placenta has performed its function; it is a foreign body in the uterus after the birth of the child, and I think the sooner it is removed the better it is for the mother.

I have seen a case of hydramnios dropsy of the ovum, which you all know is an excessive secretion of liquor amnii, distending the uterus to an enormous extent, and frequently coexistent with twin gestation, hydrocephalus and spina bifida. In this case I was called in haste; I found the woman lying across the bed with a pinched and haggard expression, caused by the squeezing of neighboring organs; there was a great discomfort from the extreme tension. She was of an enormous size, and labor pain had set in; the water broke and I delivered her of two still born male (mortified) children; both presented with the head first. On account of the enormous size of the uterus, and of the certain collapse of the uterus, she very nearly died under my hands from hemorrhage and syncope. There was some doubt about the diagnosis in the case. An eminent obstetrician was called in during her pregnancy, who had a consultation about her condition with a very prominent surgeon, and they both were in doubt about the case, as to being pregnancy or ovarian tumor, or both pregnancy and ovarian tumor combined. The cause of that doubt was due to the history of the case from the patient, she claiming that if she was pregnant that she run over her time three or four months. The physicians' doubt were strong on the side of pregnancy in spite of the misleading statement of the woman, and they were correct. The woman made a very slow recovery.

Dr. Cooper and myself performed craniotomy on a woman who was crippled and ankylosed; her thighs and knees were flexed, and almost resting on her abdomen; the pelvis was small and ankylosed; the child's head was so impacted in the pelvis that we could not move it up or down. Upon examination we found that the child was dead. We opened the cranium and delivered with forceps. She made a good recovery.

I was called by a midwife to see a woman in labor. The midwife said there was something in the pelvis; she did not know what it was. I made an examination and found a large soft tumor in the posterior part of the pelvis, and the child's head pushing it along towards the outlet. I did not know what it was—if it was a hernia, cyst, or hematoccele. I tried to guide the child's head over, and get it behind it, but did not succeed. A strong expulsive pain came on, and the mucous membrane of the vagina bursted, and the tumor was expelled, and hanging down over the perineum on a long pedicle. Another pain brought the child and the pedicle was torn from its attachment. After handing the child to the midwife I made an examination of the tumor, and found it to be a dermoid-cyst, containing hair, bones and a tooth. The rend on the mucous membrane, which was about ten inches long, healed up within one week.

During my practice I had the honor of delivering a young woman, 20 years of age, of a large female child, and the husband and father was 81 years of age. I could enumerate a good many interesting cases. I do not want to take up any more of the Society's time, and I thank you for your kind attention.

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Since reading this paper before the Saint Louis Medical Society, I have met with a case—the only one in all my practice—of complete inversion of the uterus after labor; reported to the St. Louis Medical Society and published in the March (1889) number of the St. Louis Medical and Surgical Journal.